

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR Film #G596 item #523c, 23d 1- STATE REGISTRAR 10/25/84 rja										DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 24895	
1. DECEASED NAME (TYPE OR PRINT) <b>ANNIE E. Jolley</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9-1-84</b>					2b. HOUR <b>10<sup>30</sup> P.M.</b>											
3. SEX <b>Female</b>			4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-21-84</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Smithville</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.												
10. CITY OR TOWN OF DEATH <b>Cambridge</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Dorchester</b> 13c. CITY OR TOWN <b>Smithville</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE <b>Maryland 21669</b>					13f. P.O. Box <b>87 Taylors Island</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Moses Columbus Wilson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lelia Lola Dunnock</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>217-09-7549</b>						
17. INFORMANT <b>John W. Jolley</b>					17. ADDRESS <b>P.O. Box 87 Taylors Island, Md. 21669</b>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>MASSIVE METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>INfiltrATING DUCTAL CARCINOMA OF BREAST</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>MONTHS</b> <b>7 YEARS</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>																					
19a. DATE OF OPERATION <b>JUNE 1977</b> <b>5-28-84</b>					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>LEFT MASTECTOMY</b> <b>RIGHT MASTECTOMY</b>					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (a) (this hospital) attended the deceased from <b>3-10</b> 19 <b>81</b> , to <b>9-1</b> 19 <b>84</b> , that (b) (we) lost saw the deceased alive on <b>8-29</b> 19 <b>84</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <b>James F. Mc Carter, M.D.</b>					DEGREE					22c. DATE SIGNED <b>9-2-84</b>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES F. Mc CARTER, M.D.</b>					22e. ADDRESS <b>400 AURORA STREET</b> <b>CAMBRIDGE, MD. 21613</b>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>9/6/84</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Mem. Cem.</b> <b>Bethel AME Cem.</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithville, Dor. Md. 21669</b> <b>Camb. Dor. Md.</b>						
24. FUNERAL DIRECTOR NAME <b>Boardley Funeral Home</b>					ADDRESS <b>812 Hubbard St.</b>					25. DATE REC'D. BY REGISTRAR <b>SEP 11 1984</b>					25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>						



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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 24896

1. DECEASED NAME (TYPE OR PRINT) HARRY E.A. KEENAN			2a. DATE OF DEATH MONTH DAY YEAR 9-21-84			2b. HOUR 1 a.m.			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06 30 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) executive		12b. KIND OF BUSINESS OR INDUSTRY hardware	
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 602 Water St. 21613	
14. FATHER'S NAME FIRST MIDDLE LAST Harry S. Keenan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alena Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT Frances J. Keenan		ADDRESS Item # 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH } ~24 hrs	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OBS TIA

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>9/20</u> <u>84</u> to <u>9/21</u> <u>84</u> , that (1) (we) last saw the deceased alive on <u>9/20</u> <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Hubert J. Fry</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>9/21/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Hubert J. Fry MD</u>				22e. ADDRESS <u>503 BYRN STREET</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/23/84		23c. NAME OF CEMETERY OR CREMATORY Trinity Churchyard Church Creek Dor.. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
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24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR JAP		25b. REGISTRAR'S SIGNATURE	
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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24897  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John Pollock Kniskern</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 22, 1984</b>			2b. HOUR <b>10:15<sup>A</sup></b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 22 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b> MD			
10. CITY OR TOWN OF DEATH <b>Hurlock</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hunting Creek Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Quality Control/Hardware</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>MD Dorchester Hurlock</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Hunting Creek Road/21643</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Austin Kniskern</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pauline Paterson Pollock</b>			16. ADDRESS <b>Rt. 2, Box 62B</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI</b>		17. INFORMANT ADDRESS <b>Margaretta Kniskern Hurlock, MD 21643</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic obstructive lung disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Suspect hamangioma carcinoma of lung (not histologically proven)</b>									
19a. DATE OF OPERATION <b>~</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>~</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>79</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>79</b>		CITY OR TOWN <b>79</b>		COUNTY <b>84</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>9/22</b> 19 <b>84</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>2 weeks prior</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>9-23-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Delmarva Crematory</b>		23d. LOCATION CITY OR TOWN <b>Lewes, Sussex, Delaware</b>	
24. FUNERAL DIRECTOR NAME <b>Zeller Funeral Home, East New Market, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 5 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Wanda Davidson-Randall</b>			

BP

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of a transaction into the ledger to the final reconciliation of the accounts.

3. The third part of the document discusses the role of the auditor in ensuring the accuracy of the financial records. It describes the various techniques used by auditors to verify the information provided by the company and to identify any potential areas of concern.

4. The fourth part of the document provides a summary of the key points discussed in the previous sections. It reiterates the importance of accurate record-keeping and the role of the auditor in maintaining the integrity of the financial system.

5. The fifth part of the document contains a list of references and a bibliography. It includes a list of books, articles, and other sources that were consulted during the preparation of the document.

6. The sixth part of the document is a conclusion. It summarizes the main findings of the study and provides recommendations for further research. It also includes a list of appendices and a list of figures.

7. The seventh part of the document is a list of references and a bibliography. It includes a list of books, articles, and other sources that were consulted during the preparation of the document.

8. The eighth part of the document is a conclusion. It summarizes the main findings of the study and provides recommendations for further research. It also includes a list of appendices and a list of figures.

9. The ninth part of the document is a list of references and a bibliography. It includes a list of books, articles, and other sources that were consulted during the preparation of the document.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24898 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) OTIS			FIRST OTIS MIDDLE CARROLL LAST LE COMPT JR.			2a. DATE OF DEATH MONTH DAY YEAR 9 23 84			7b. HOUR 7:05 PM		
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH AUG. 31 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.			7a. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.					
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION DORCHESTER GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REPAIRMAN			12b. KIND OF BUSINESS OR INDUSTRY C & P TEL.CO.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. CITY OR TOWN DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Star Rt. Box 7, Cambridge, Md. 21613		
14. FATHER'S NAME FIRST OTIS MIDDLE CARROLL LAST LE COMPT			15. MOTHER'S MAIDEN NAME FIRST BERTIE MIDDLE ADKINS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II 217-12-4041		17. INFORMANT wife Mrs. Betty Pritchett L. LeCompte						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>GASTROINTESTINAL HEMORRHAGE, SHOCK, ANEMIA</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>84</u> , to <u>9/23</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>9/23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Michael A. Moskewicz MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/23/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MICHAEL A. MOSKEWICZ MD</u>			22e. ADDRESS <u>503 BYEN ST. CAMBRIDGE MD</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>			23b. DATE <u>9/26/84</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Md. Vets. Cem. of E.S.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>BEULAH, DORCHESTER, MD.</u>		
24. FUNERAL DIRECTOR NAME <u>CURRAN FUNERAL HOME</u> ADDRESS <u>308 High</u> <u>CAMBRIDGE, MD. 21613</u>						25a. DATE REC'D. BY REGISTRAR <u>SEP 26 1984</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



1



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24899  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Eugene N. LYONS			2a. DATE OF DEATH MONTH DAY YEAR 9/30/84			7b. HOUR 3:15 A.M.				
3. SEX M		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 19 21		6. AGE (IN YEARS LAST BIRTHDAY) 63		7a. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.				
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UPHOLSTERY		12b. KIND OF BUSINESS OR INDUSTRY SELF EMP.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1212 Race St. 21613	
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR LYONS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NORA CAREY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II 217 28 4421		17. INFORMANT ELIZABETH LYONS				ADDRESS ITEM #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Functioning Pacemaker in place										
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept 30, 1984 to Sept 30, 1984, that (I) (we) lost view of the deceased alive on Sept 30, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. Neal Reynolds			22c. PHYSICIAN'S NAME (TYPE OR PRINT) H. Neal Reynolds			22d. ADDRESS 408 Byron St, Cambridge Md			22e. DATE SIGNED 9/30/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/2/84		23c. NAME OF CEMETERY OR CREMATORY CAMBRIDGE CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE CAMBRIDGE DOR. MD.		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR OCT 6 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson		

BP

100-2-1

NAME: [illegible] SURNAME: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

SEX: [illegible] MARITAL STATUS: [illegible]

EDUCATION: [illegible] OCCUPATION: [illegible]

RELIGION: [illegible] POLITICAL AFFILIATION: [illegible]

RESIDENCE: [illegible]

CONTACT INFORMATION: [illegible]

ADDITIONAL INFORMATION: [illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 13e per phone 9/25/84 dad STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH <b>2 4 9 0 0</b> REG. NO.															
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>George Guy McGlaughlin</b>					2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>9- 9 19 84</b>					2b. HOUR <b>7PM</b>					
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 15 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9- 9- 19 84</b>		2d. HOUR <b>7:50</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b>			
10. CITY OR TOWN OF DEATH <b>Cambridge</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waterman-self</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>employed</b>			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Andrews</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rural</b>		<b>21613</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wilbur McGlaughlin</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pauline Slacum</b>									
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>						16b. SOCIAL SECURITY NO. <b>213-22-7353</b>		17. INFORMANT ADDRESS <b>Dorothy W. McGlaughlin Andrews Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obstructive lung disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>John Mace Jr.</i>						TITLE (SPECIFY) <b>Deputy</b>						DATE SIGNED <b>9/10/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John Mace Jr.</b>						ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>				23b. DATE <b>9/12/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Pk.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor. Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1984</b>				25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Rendell</i>					

FROM LIBRER

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*[Handwritten signature]*  
7/11/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				24901 REG. NO.			
1. FOR STATE REGISTRAR							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charlotte T. Merrick</b>				2a DATE OF DEATH MONTH DAY YEAR <b>Sept. 7 1984</b>		2b HOUR <b>0630</b> M	
3 SEX <b>female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>06 22 1942</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10 CITY OR TOWN OF DEATH <b>E. New Market</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>N. Main St.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>secretary</b>		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b>				13b COUNTY <b>Dor.</b>		13c CITY OR TOWN <b>E. New Market</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Myron W. Thomas</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Brinsfield</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>213-42-0004</b>		17 INFORMANT <b>Linford G. Merrick</b>		ADDRESS <b>P.O. Box 156 E. New Market</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA ENDOMETRIUM</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1982</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/4/82</b> 19____, to <b>9/7/84</b> 19____, that (I) (we) last saw the deceased alive on <b>7/12/84</b> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>CRW Bain</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/10/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CRW BAIN</b>		22e. ADDRESS <b>Easton, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>9/9/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>E. New Market</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>E. New Market Dor. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>				ADDRESS <b>CAMBRIDGE MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1984</b>	
				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

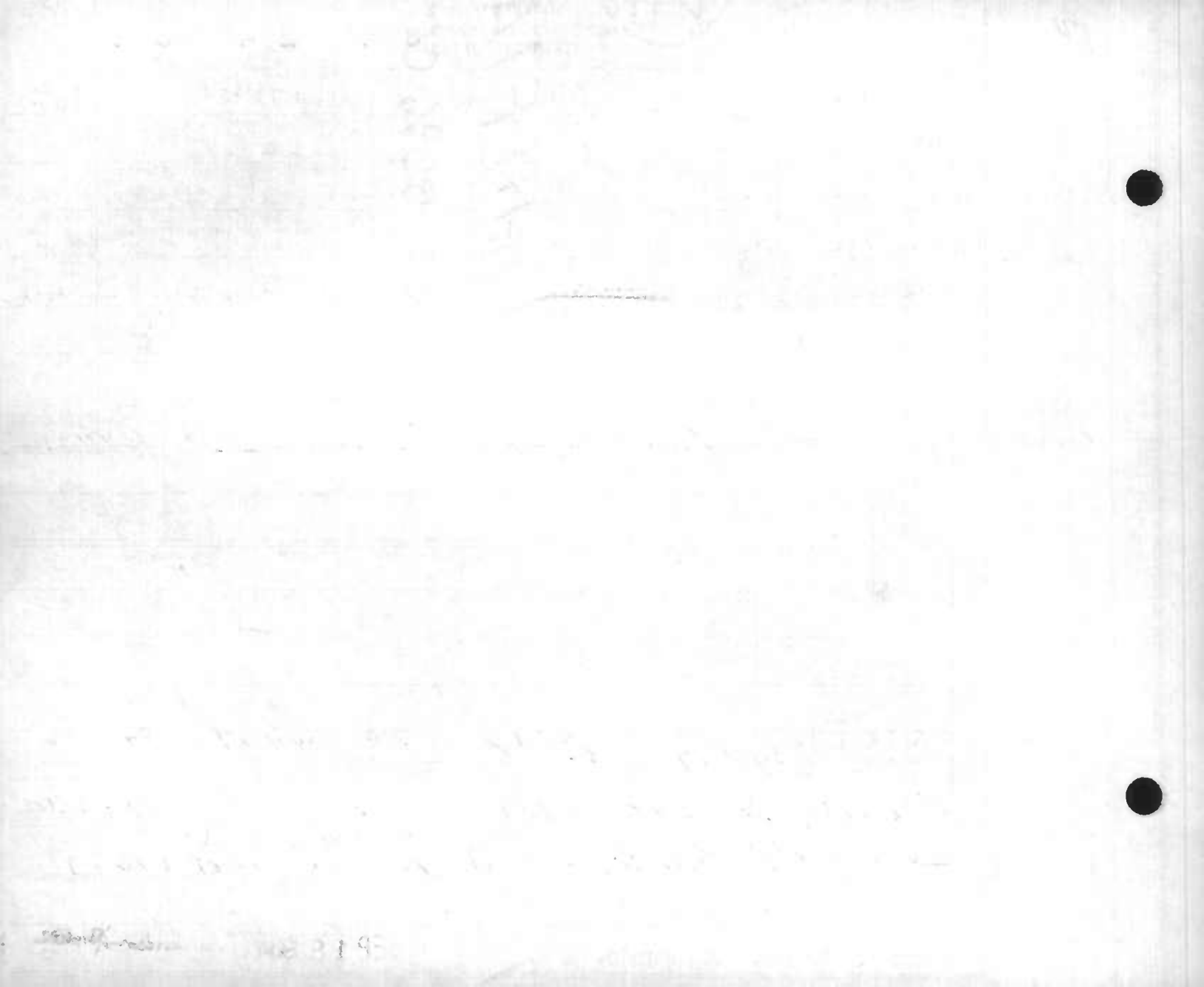
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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24902  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank L. Mewshaw		2a. DATE OF DEATH MONTH DAY YEAR 9/17/84		2b. HOUR 10 AM	
3. SEX M	4. RACE Cau	5. DATE OF BIRTH MONTH DAY YEAR 06 17 22		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD	
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Store owner
13a. STATE Maryland		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS P.O. Box 217 Hurlbush 21643
14. FATHER'S NAME FIRST MIDDLE LAST Frank L. Mewshaw Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Loretta Klug			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-364290		17. INFORMANT ADDRESS Marie B. Mewshaw, Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myelocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1984</u> to <u>Sept 17 1984</u> , that (I) <del>was</del> lost saw the deceased alive on <u>Sept 17 1984</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) did not view the body after death.					
22b. SIGNATURE <u>Lewis M. Burdette MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 17 Sept 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Burdette		22e. ADDRESS 4 Arara St Cambridge MD 21617			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 20, 84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD		23d. LOCATION CITY OR TOWN Glen Burnie		23e. COUNTY AA	
25a. DATE REC'D. BY REGISTRAR SEP 18 1984		25b. REGISTRAR'S SIGNATURE John Davidson			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24903 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES G. MOFFITT</b>					20. DATE OF DEATH MONTH DAY YEAR <b>9 24 84</b>			26. HOUR <b>0230</b> M			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 05 1885</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>99</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dor., Cambridge</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>chart maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>steel</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>					13b. CITY OR TOWN <b>Dor.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>Cambridge</b>		13e. STREET ADDRESS / ZIP CODE <b>311 Glenburn Ave. 21613</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Moffitt</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unk. unk.</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>171-09-4157</b>		17. INFORMANT ADDRESS <b>6311 Heritage Lane Margaret Nessen Bradenton Fla.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma of transverse colon with perforation</b> DUE TO, OR AS A CONSEQUENCE OF <b>diverticulitis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Adenocarcinoma of prostate. Uremia</b>											
19a. DATE OF OPERATION <b>Sept 16, 1984</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Peritonitis</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET <b>Cambridge</b>		CITY OR TOWN <b>MD.</b>		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 16</b> , 19 <b>84</b> , to <b>Sept 24</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Sept 24</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Lewis M. Burdette MD</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>29 Sept 84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lewis M. Burdette</b>					22e. ADDRESS <b>4 Aurora St Cambridge MD 21613</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>9/26/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>E. New Market Cem.</b>		23d. LOCATION CITY OR TOWN <b>E. NEW MARKET</b>		COUNTY <b>DOR.</b>		
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>					ADDRESS <b>CAMBRIDGE MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 27 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 4 9 0 4 REG. NO.
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) <b>KENNIE L. NICHOLS</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>9-19-84</b>		2b. HOUR <b>M</b>		
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 21, 1894</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD <b>9-19-84</b>	2d. HOUR <b>7:30P</b>		2e. HOUR <b>M</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cokesbury, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Dorchester</b>	13c. CITY OR TOWN <b>Seaford</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 3, Box 257</b> <b>21613</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John F. Nichols</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Ann</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWI</b>				
16b. SOCIAL SECURITY NO. <b>221-05-6330</b>				17. INFORMANT ADDRESS <b>Jessie L. Payne, Rt. 1, Box 332, Seaford, Delaware 19983</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Smoke and soot inhalation and thermal burns</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY <b>2:30P. MON. 9-19-84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject found in burning car as a result of a house fire</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>residence</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 3 Box 257 Cokesbury Rd. Dorchester Co., Md.</b>						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>Assistant MEDICAL EXAMINER</b>				DATE SIGNED <b>9-20-84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 22, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Frampton-Hawkins Funeral Home</b>				ADDRESS <b>Federalsburg, Md., 21613</b>				BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER COUNTY</b>		



ORIGINAL

FILED

U.S. DEPARTMENT OF JUSTICE  
DIVISION OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24905 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>Everett</u>						2a. DATE OF DEATH MONTH <u>9</u> DAY <u>6</u> YEAR <u>84</u>		2b. HOUR <u>5<sup>PM</sup></u>			
3. SEX <u>MALE</u>		4. RACE <u>CAU.</u>		5. DATE OF BIRTH <u>Sept. 15, 1891</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>92</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>DORCHESTER</u> MD.					
10. CITY OR TOWN OF DEATH <u>Cambridge</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Cambridge House Nursing Fac.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>waterman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>shellfish</u>			
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>DORCHESTER</u>		13c. CITY OR TOWN <u>CAMBRIDGE</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>520 Glenburn Ave.</u>			
14. FATHER'S NAME FIRST <u>SAMUEL</u> MIDDLE <u></u> LAST <u>PHILLIPS</u>						15. MOTHER'S MAIDEN NAME FIRST <u>JENNY</u> MIDDLE <u></u> LAST <u>WALLACE</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u></u>		17. INFORMANT ADDRESS <u>Helen Brown,</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrosclerosis - chronic renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senility</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>5 yrs</u> <u>2 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u></u> P.M. <u></u> 19 <u></u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/12/84</u> 19 <u></u> to <u>9/6/84</u> 19 <u></u> , that (I) (we) lost saw the deceased alive on <u>9/3/84</u> 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
27b. SIGNATURE <u>Lawrence Marynor, M.D.</u>						DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lawrence Marynor, M.D.</u>						27e. ADDRESS <u>610 Race St. Cambridge, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>			23b. DATE <u>9/8/84</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Hosier Mem. Church</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hooper's Isl. Dor. Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Curran, 308 High St., Cambridge, Md.</u>						25a. DATE REC'D. BY REGISTRAR <u>SEP 11 1984</u>			25b. REGISTRAR'S SIGNATURE <u></u>		

BP \_\_\_\_\_

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THE EXAMINER

10% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				24906 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CARL L. SIMMONS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9 29 84</b>			
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 12 00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DORCHESTER GENERAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POULTRY FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>md.</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN T. SIMMONS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ETTA HUGHES</b>		13e. STREET ADDRESS / ZIP CODE <b>RFD 3-150 21013</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-32-9782</b>		17. INFORMANT ADDRESS <b>ALICE GIORDANO 7 SUNSET LANE CAMBRIDGE MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASHD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>sev. yrs.</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M. S. SHARIT, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/29/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Yusef</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-2-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DOR. MEM PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CAMBRIDGE DOR. MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE MD</b>				25a. DATE REC'D. BY REGISTRAR <b>5 1984</b>			
				25b. REGISTRAR'S SIGNATURE <b>Guth Davidson-Randall</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				24907	
1. DECEASED NAME (TYPE OR PRINT) <b>Ora E. Singleton</b>				20. DATE OF DEATH MONTH DAY YEAR <b>9-22-84</b>	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>January 23, 1932</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b>	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dietician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lankunal Hospital</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>	13c. CITY OR TOWN <b>Hurlock</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>P.O. Box 422 21643</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Smith</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maybelle Brown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>248-52-3297</b>		17. INFORMANT ADDRESS <b>Mamie Gibson, Box 422, Hurlock, Md. 21643</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic and Cirrhosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Laennec's Liver Cirrhosis</b>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 20, 1984</b> to <b>September 12, 1984</b> , that (I) (we) last saw the deceased alive on <b>September 12, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Carlos F. Barroso</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-12-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carlos F. Barroso</b>		22e. ADDRESS <b>Hurlock Md. 21614</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 15, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Johns Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Preston, Caroline, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 19 1984</b>			
24. FUNERAL DIRECTOR NAME <b>FRAMPTON-HAWKINS</b>		24b. ADDRESS <b>FEDERSBURG</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

9-12-84

2-10-84

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January 21, 1982

Jack

Wagon

Amherst

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South Carolina

Washington

Director General Hospital

Director

SLV for X

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21-12-84

no

12-12-84

12-12-84

12-12-84

Director General Hospital

Director General Hospital

Director

Director

Director

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

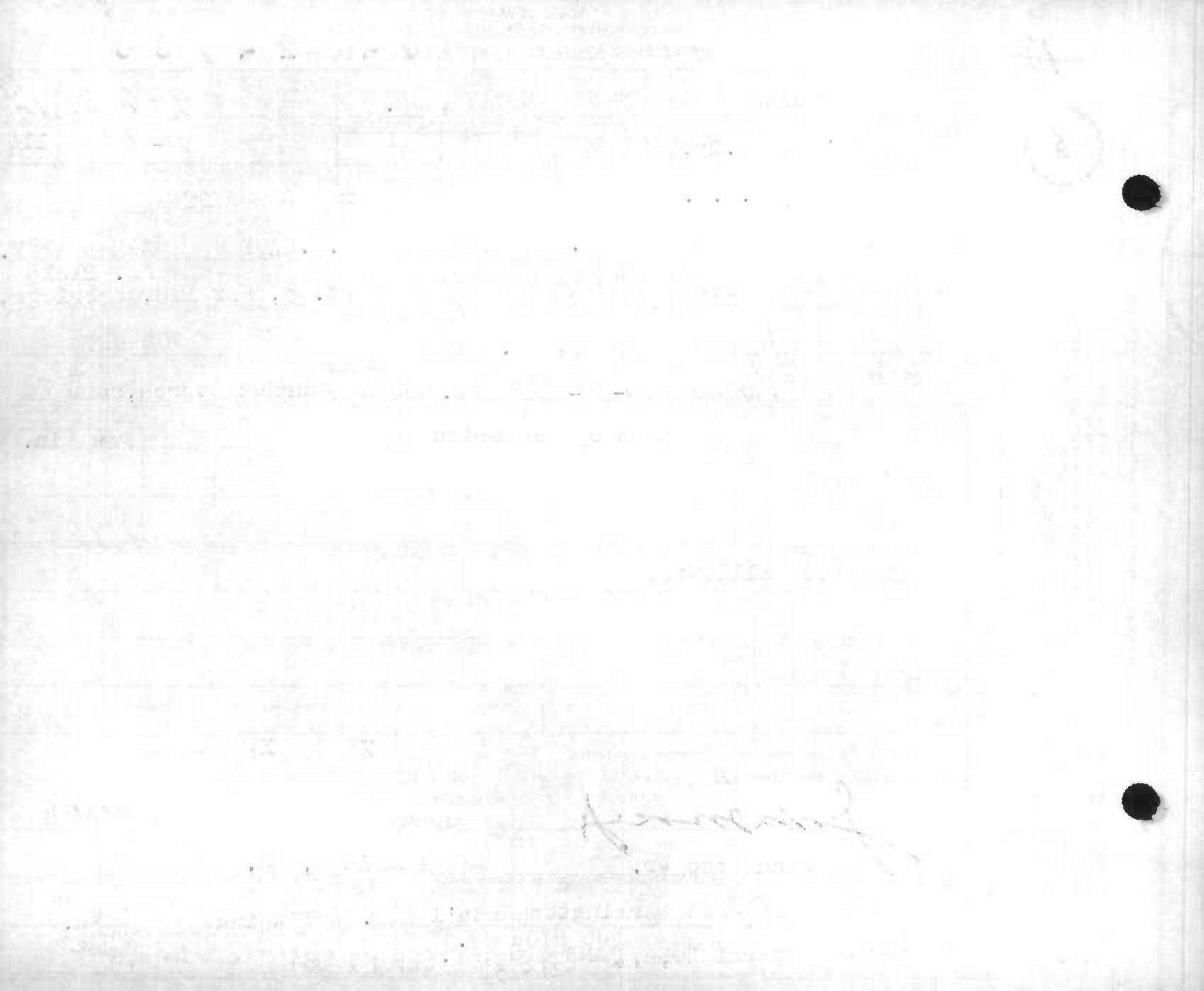
BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 4 9 0 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALLACE GARRETT STORCH, JR.										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9-6-84				2b. HOUR 9:35 AM					
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-6-84				2d. HOUR 11A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.							
10. CITY OR TOWN OF DEATH CAMBRIDGE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GEN. HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. NAVY				12b. KIND OF BUSINESS OR INDUSTRY ARMED SERV.					
13a. STATE MARYLAND										13b. COUNTY DORCHESTER		13c. CITY OR TOWN ROSS NECK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 3, Box 118, Cambridge, Md. 21613			
14. FATHER'S NAME FIRST MIDDLE LAST WALLACE GARRETT STORCH, SR.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELE FOURNET									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				(IF YES, GIVE WAR OR DATES) WW II, KOREAN		16b. SOCIAL SECURITY NO. 550-38-4864		17. INFORMANT mother ADDRESS Mrs. Adele Fournet Storch, same as 13 e											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Min.																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Diabetes Mellitus																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE John Mace Jr.										TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				DATE SIGNED 9/6/84					
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr.										ADDRESS Cambridge, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 9/10/84		23c. NAME OF CEMETERY OR CREMATORY Arlington Natn'l Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.									
24. FUNERAL DIRECTOR NAME Curran Funeral HOME, 308 HIGH ST. CAMBRIDGE, MD. 21613										25a. DATE REC'D. BY REGISTRAR SEP 11 1984						25b. REGISTRAR'S SIGNATURE John Davidson-Randall			





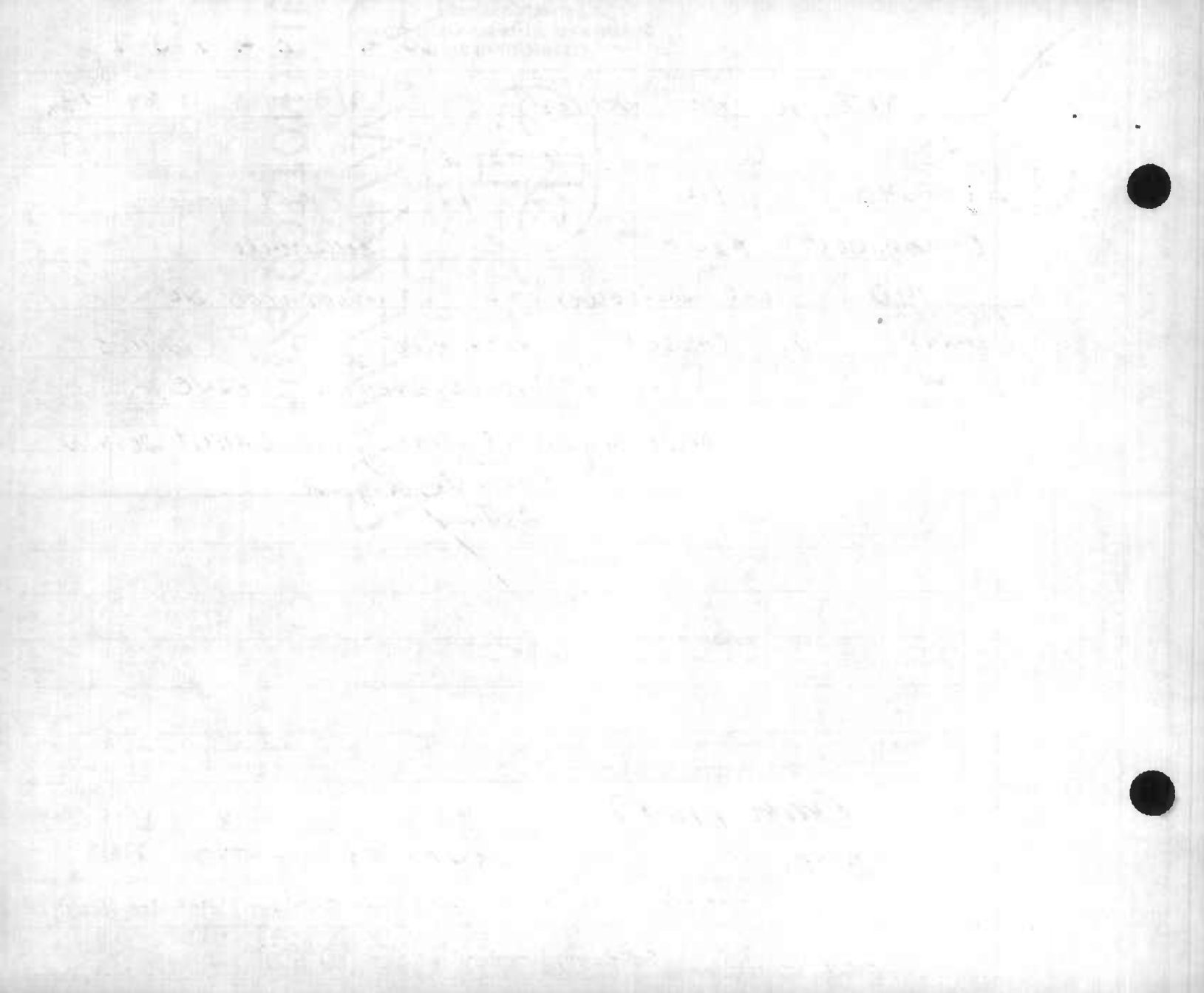
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the medical examiner after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24909 REG. NO.	
1. FOR STATE REGISTRAR I. DECEASED NAME (TYPE OR PRINT) <b>Kathryn Taylor</b> <i>Kathryn Causey Taylor</i>						2a. DATE OF DEATH MONTH DAY YEAR <b>9/15/84 9 15 84</b>		2b. HOUR <b>7<sup>16</sup> PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-13-35</b>		6. AGE (IN YEARS, LAST BIRTHDAY) <b>49</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester MD</b>					
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ESHC</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>Wic</b>		13c. CITY OR TOWN <b>SALISBURY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>KINGSWOOD DR #1801</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>LARRY J. CAUSEY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATHERINE WILLIS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>217-30-8906</b>		17. INFORMANT ADDRESS <b>DONNA BREWER ESHC, Cambridge, Md</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest plus Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>due to aspiration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } <b>Severe emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Asthma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I. OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE <b>M. Sadri, M.D.</b>						22c. DATE SIGNED <b>9/15/84</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. SADRI</b>				22e. ADDRESS <b>ESHC, Cambridge, Maryland 21613</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/18/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Holloway Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 20 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John S. ...</i>					





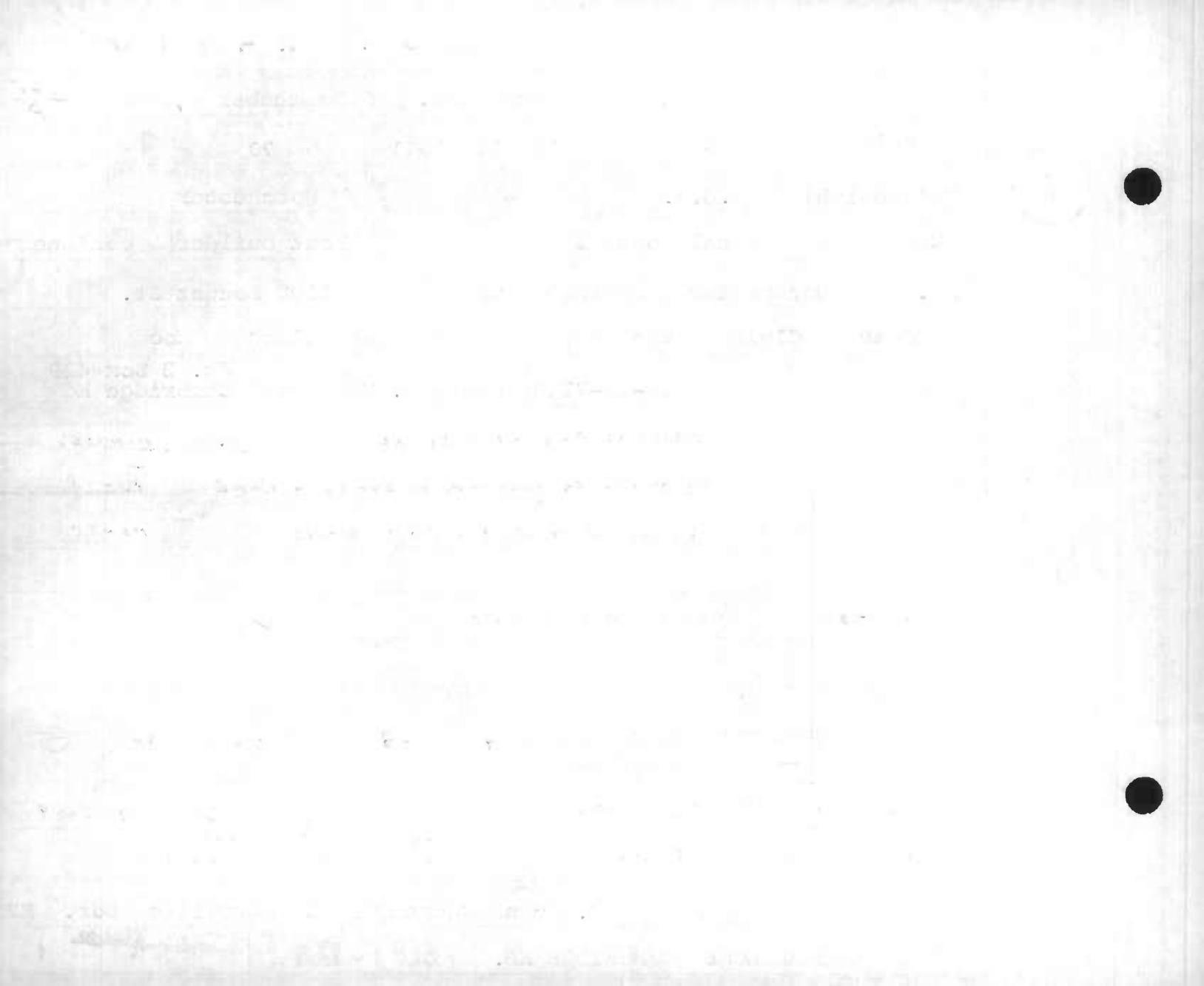
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24910  
REG. NO.1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Edgar C. VanDyke Jr.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>September 6, 1984</b>		2b. HOUR <b>4<sup>45</sup> PM</b>	
3 SEX <b>male</b>	4 RACE <b>white</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>09 11 1910</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Philadelphia</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10 CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rural Route 2</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>boat builder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>&amp; designer</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dorchester</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET ADDRESS <b>1108 Locust St.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edgar Clair Van Dyke</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kathrine Clark Hood</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-26-7340</b>		17. INFORMANT ADDRESS <b>Rt. 2 Box 429 Cambridge Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC SQ. CELL CA. TO LUNGS &amp; BONE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SQ. CELL CA. OF RT. PIRIFORM SINUS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>MONTHS</b> <b>MONTHS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>8-10-84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BIOPSY, MASS IN NECK</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I, (the hospital)) attended the deceased from <b>8-4</b> , 19 <b>84</b> , to <b>9-6</b> , 19 <b>84</b> , that (I, (we)) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I, (we)) did (did not) view the body after death.					
22b. SIGNATURE <b>James F. McCarter, M.D.</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9-6-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES F. MCCARTER, M.D.</b>		22e. ADDRESS <b>400 AURORA STREET CAMBRIDGE, MD. 21613</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>9/8/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Churchyard</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dor. Md</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE MD.</b>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>SEP 13 1984</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 8-4										24911 REG. NO.	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LULA M WEIBE					2a. DATE OF DEATH MONTH DAY YEAR 9 8 84			2b. HOUR 2:35 P.M.			
3. SEX F		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 10 25 11		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.					
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY DORC		13c. CITY OR TOWN CAMP		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 3 Box 197 21613			
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS HEINZENBERGER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA M POLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-22-8887		17. INFORMANT ADDRESS GEORGE WEIBE SAME							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 245 min											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a DIABETES MELLITUS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9/8 1984, to 9/8 1984, that (I) (we) last saw the deceased alive on 9/8 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE H L Fierly			DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/8/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT L. FIERLY MD			22e. ADDRESS 503 BYRN ST. CAMP. MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 9/11/84		23c. NAME OF CEMETERY OR CREMATORY Seward Spedden Cen.		23d. LOCATION CITY OR TOWN COUNTY STATE Hills Point Dor. Md.				
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR SEP 14 1984						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24912  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William G Arrison			2a. DATE OF DEATH MONTH DAY YEAR Sept 10, 1984			2b. HOUR 7:45 P.M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 16, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ironworker		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Elliotts Isl.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Elliotts Island 21823			
14. FATHER'S NAME FIRST MIDDLE LAST Elwood Arrison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Bradshaw							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 151-20-6444		17. INFORMANT ADDRESS William E. Arrison 317 Weatherby Ave. Swedesboro							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UNDIFFERENTIATED METASTATIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEK</u> <u>10 MONTHS</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET —		CITY OR TOWN —		COUNTY —		STATE —	
22a. I certify that (a) (this hospital) attended the deceased from <u>JAN</u> , 1984, to <u>SEPT 10</u> , 1984, that (b) (we) last saw the deceased alive on <u>Sept 10</u> , 1984, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (do) (did not) view the body after death.											
22b. SIGNATURE Michael A. Moskewicz MD				DEGREE MD				22c. DATE SIGNED 9/10/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ MD				22e. ADDRESS 503 134th ST CAMBRIDGE MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 13, 1984		23c. NAME OF CEMETERY OR CREMATORY Friendship Cem.		23d. LOCATION CITY OR TOWN Monroeville, Glos. N.J.		COUNTY —		STATE —	
24. FUNERAL DIRECTOR NAME Curran Funeral Home				ADDRESS 308 High St. Cambridge, Md.		25a. DATE REC'D. BY REGISTRAR SEP 14 1984		25b. REGISTRAR'S SIGNATURE S. Davidson-Randall			

BP

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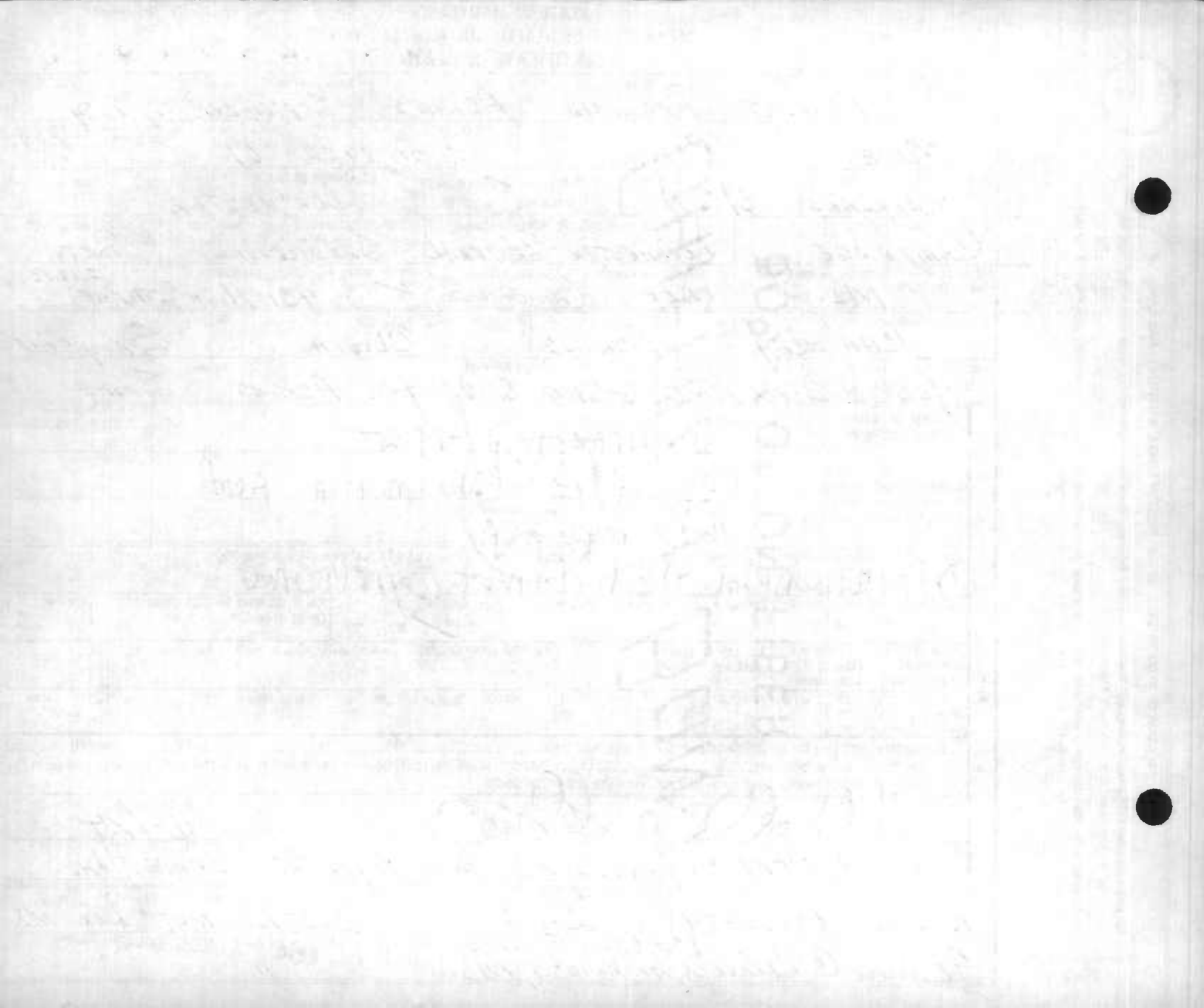
# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

2 4 9 1 3

1. DECEASED-NAME (Type or print) <b>ALBERT REGINALD ASKINS</b>			2a. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>1</b> Year <b>1984</b>			2b. HOUR <b>M</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH <b>OCT. 20, 1922</b>		6. AGE (In years last birthday) <b>61</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>DORCHESTER</b> Md.	
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DORCHESTER GENERAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SERVICE MAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RTI</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>DOR.</b>		13c. CITY OR TOWN <b>CAMBRIDGE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>431 HIGH STREET</b>		13f. CITY OR TOWN <b>CAMBRIDGE</b>		13g. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13h. STREET AND NUMBER <b>21613</b>	
14. FATHER'S NAME First Middle Last <b>CHAUNCEY ASKINS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>OLIVIA SAMPSON</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>215-X6-8900</b>		17. INFORMANT <b>ENDERLYNE ASKINS</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO <b>AS A CONSEQUENCE OF</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Upper Lobe PNEUMONIA AND</b> DUE TO <b>AS A CONSEQUENCE OF</b> (c) <b>EMPHYSEMA</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PARKINSONISM 2) SHY DRAPER SYNDROME</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>H. Neal Reynolds</b>		22c. DATE SIGNED <b>9/1/84</b>		22d. PHYSICIAN'S NAME (Type) <b>H. NEAL REYNOLDS MD.</b>		22e. ADDRESS <b>408 BYRU ST. CAMB. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>09-05-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ZION</b>		23d. LOCATION (City or Town) (County) (State) <b>EAST NEW MKT. DOR. MD</b>	
24. FUNERAL DIRECTOR <b>Frederick C. [unclear]</b>		25a. REC'D BY REGISTRAR <b>SEP 7 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[unclear]</b>			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24914  
REG. NO.1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Bettie M. Baltimore</b>			2a DATE OF DEATH MONTH DAY YEAR <b>09-21-84</b>			2b HOUR <b>7<sup>20</sup> A.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>01 06 21</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NO. CAROLINA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b> MD.			
10 CITY OR TOWN OF DEATH <b>CAMPBELL</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester GENERAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
13a STATE <b>MD</b>			13b COUNTY <b>Dorchester</b>		13c CITY OR TOWN <b>VIENNA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Holden</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY PERRY</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			
16b SOCIAL SECURITY NO. <b>218-22-5991</b>			17 INFORMANT ADDRESS <b>Jenny Baltimore 62 Greenwood Ave</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last (b) <b>Chronic renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetic glomerulonephritis</b>								<b>1 year</b> <b>1 year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Chronic brain syndrome due to arteriosclerosis</b>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>January 6, 1980</b> to <b>September 21, 1984</b> , that (I) (we) last saw the deceased alive on <b>September 21, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Dr. F. Barro</b> MD						DEGREE <b>MD</b>		22c. DATE SIGNED <b>9.21.84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carlos F Barroso</b> MD						22e ADDRESS <b>Harlock Md 21643</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremial</b>			23b DATE <b>9-24-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wc. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>West Funeral Salis, Md.</b>						13a DATE REC'D. BY REGISTRAR 13b REGISTRAR'S SIGNATURE <b>SEP 27 1984 John Davidson-Hopkins</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 4 9 1 5  
REG. NO.

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)										2b. DATE KNOWN OF ESTI- DEATH MATED		2c. DATE PRONOUNCED DEAD		2d. HOUR	
		William Albert Boevers										9-30-84		PM		9:40 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Male		White		4 24 64		20 YRS.						Sept. 30 1984		9:40 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Germany				USA								Dorchester County MD.					
11. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge				Dorchester General				Laborer/Seafood				Packing					
10a. STATE				10b. COUNTY				10c. CITY OR TOWN				10d. INSIDE CITY LIMITS?					
MD				Dorchester				Secretary				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13d. STREET ADDRESS				13e. STREET ADDRESS				13f. STREET ADDRESS				13g. STREET ADDRESS					
106 South Street/21664				106 South Street				106 South Street				106 South Street					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16. SOCIAL SECURITY NO.				17. INFORMANT					
William G. Boevers				Tuetje Wellhoener				217-92-5905				William Boevers Secretary, MD 21664					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				106 South Street					
No				217-92-5905				William Boevers Secretary, MD 21664				106 South Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicide by hanging</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Few Mins.</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
9PM 9-30-1984				Hanged himself on telephone pole.													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
Street				Moose Lodge Rd. Nr Cambridge, Dor. Md.													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
John Mace Jr.				Deputy				10/3/84									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
John Mace Jr. M.D.				Cambridge, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				10-3-84				East New Market Cem				East New Market, Dorch., MD					
24. FUNERAL DIRECTOR (NAME)				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Zeller Funeral Home				OCT 8 1984													





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 4										24916 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>CYRIL E CHILDE</b>				2a. DATE OF DEATH MONTH <b>9</b> DAY <b>13</b> YEAR <b>84</b>				2b. HOUR <b>11:05</b> AM			
3. SEX <b>M</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>19</b> YEAR <b>87</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 72 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEBRASKA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER CO.</b> MD.					
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DORCHESTER GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRANSPORTATION CONSULTANT</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>DORCHESTER</b>		13c. CITY OR TOWN <b>CAMBRIDGE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>RT. #4 BOX 277 21613</b>			
14. FATHER'S NAME FIRST <b>EDWARD</b> MIDDLE <b>P</b> LAST <b>CHILDE</b>				15. MOTHER'S MAIDEN NAME FIRST <b>LUCY</b> MIDDLE <b></b> LAST <b>MITCHELL</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578-38-8767</b>		17. INFORMANT <b>WIFE - FRANCES</b>				ADDRESS <b>SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC DISCRIMYTAMIA TO STAND STILL</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>TERMINALLY</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE ANTERIOR WALL MYOCARDIAL INFARCTION 21 DAYS</b> <b>WITH VENTRICULAR ANEURYSM</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC CORONARY ARTERY DISEASE</b> <b>10+ YEARS</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>9-24, 1980</b> , to <b>9-13, 1984</b> , that (I) (we) lost saw the deceased alive on <b>9-13, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE <b>Donald R. McWilliams</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9-14-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD R. McWILLIAMS, M.D.</b>						22e. ADDRESS <b>308 GAY ST. CAMBRIDGE, MD. 21613</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>9/14/84</b>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>						ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1984</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. Anderson-Russell</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24917  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PERCY JAMES DAVIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 9, 1984</b>		2b. HOUR <b>7:30 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 6, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b> MD.	
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>701 RACE STREET A. 414</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>RET.</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>DOR.</b>	13c. CITY OR TOWN <b>CAMBRIDGE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES DAVIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PEARL TAYLOR</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-10-8089</b>		17. INFORMANT ADDRESS <b>FLOSSIE MAE DAVIS SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for 10a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Heart Disease, Angina</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>2 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10c) <b>Coronary Heart Disease, Angina</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>1979</b> 19 <b>—</b> , to <b>9.9</b> 19 <b>84</b> , that (1) (we) last saw the deceased alive on <b>6-05-84</b> 19 <b>—</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) did not view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE		22c. DATE SIGNED <b>9.10.84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANN R. WILKE, M.D.</b>		22e. ADDRESS <b>400 MARYLAND AVE CAMB., MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>09-15-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. PLEASANT</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SOLEM DOR. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>STANLEY C. ALLEN</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 11 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[The page contains extremely faint, illegible handwritten text, likely bleed-through from the reverse side. The text is organized into several paragraphs and possibly a list or table structure, but the characters are too light to transcribe accurately.]*

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 4 9 1 8	
1. DECEASED NAME (TYPE OR PRINT) <b>Essie Mae Ennals</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <b>9/3</b> DAY <b>19</b> YEAR <b>84</b>		2b. HOUR <b>AM</b>		
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH <b>Dec.</b> DAY <b>2</b> YEAR <b>1935</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		7c. DATE PRONOUNCED DEAD <b>Sept. 3, 1984</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b>		
11. CITY OR TOWN OF DEATH <b>Cambridge</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DCA Dorchester General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>618 Greenwood Ave</b>			
14. FATHER'S NAME FIRST <b>Grant</b> MIDDLE <b>Thomas</b> LAST <b>Ennals</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Christine</b> MIDDLE <b>Johnson</b> LAST <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-32-7551</b>		17. INFORMANT <b>Betty Ennals</b>				ADDRESS <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Congestive Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>?</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John Mace Jr.</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				DATE SIGNED <b>9/3/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John Mace Jr. M.D.</b>				ADDRESS <b>Cambridge, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/8/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge, Dor. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Stewart Funerals Cambridge, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 6 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Lidia Davidson-Randall</b>			

OPTION WIRE

END



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 49819

1. FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH										3. MONTH DAY YEAR										4. HOUR																																							
1a. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										3. MONTH DAY YEAR										4. HOUR																																							
Frank Charles Haring										9-29										1984										PM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										7. IF UNDER 1 YR.										8. IF UNDER 24 HRS.																			
male										white										08 26 1917										67 YRS.										MONTHS DAYS HOURS MIN.										2c. DATE PRONOUNCED DEAD										2d. HOUR									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH										10. HOUR																													
Md.										U.S.A.																				Dorchester										1:30 PM																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																							
Cambridge										505 Gay St.										repairman-self										emp.																																							
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS										13f. ZIP CODE																			
Md.										Dor.										Cambridge										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										505 Gay St.										21613																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																			
Frank Chase Haring										Norma Toffling										Yes										WW 2										Louise Polaski										7876 Belhaven Beach Pasadena Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										19. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																							
PART I DEATH WAS CAUSED BY:																														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>																																																																					
DUE TO, OR AS A CONSEQUENCE OF																																																																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																																																					
(b) <u></u>																																																																					
DUE TO, OR AS A CONSEQUENCE OF																																																																					
(c) <u></u>																																																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																																																																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																	
										P.M.																																																											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																																																	
																				STREET										CITY OR TOWN										COUNTY										STATE																			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:																																																																					
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																					
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																	
John Mace Jr.										M.D. Deputy										MEDICAL EXAMINER										10/1/84																																							
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																											
John Mace Jr. M.D.										Cambridge, Md.																																																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION										23e. REGISTRAR'S SIGNATURE																													
Cremation										10/1/84										DELMARVA CREMATORY										CAPE HENLOPEN										DELAWARE																													
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
THOMAS FUNERAL HOME										5 1984										Julia Davidson-Randall																																																	
NAME										ADDRESS																																																											

